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DEPARTMENT OF HEALTH A	ND HUMAN SERVICE	S
CENTERS FOR MEDICARE &	MEDICAID SERVICE:	3

PRINTED: 06/29/2007 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING		(X3) DATE SURVEY COMPLETED	
		09 G 174	B. WING		06/24	6/2007
NAME OF F	ROVIDER OR SUPPLIER		442	ET ADDRESS, CITY, STATE, ZIP CODE 22 20TH STREET, NE ASHINGTON, DC 20011		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	DATE COMPLETION (X5)
W 000	INITIAL COMMEN	TAL COMMENTS W DOD		-		
	Surveyor: 19076	·				
W 104	25, 2007 thru June initiated using the however, as a restinction reports are extend the survey Protections. A rar was selected from males with various findings were base home and three dwith clients, reside administrative stainvestigations of conducted. The set the facility failed to Condition of Partic 483,410(a)(1) GOThe governing bo	arvey was conducted from June 226, 2007. The survey was fundamental survey process; alt of the review of unusual ad interviews, it was decided to process in the area of Client adom sample of three clients a resident population of six a disabilities. The survey ed on observations in the group ay programs, and Interviews ential, day program, nursing and if. Review of records, including anusual incidents was also survey findings determined that a substantially comply with the cipation in Client Protection. INTERNING BODY	W 104		701 JUL 25 P 3: 36	DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION
	This STANDARD Surveyor: 19076	is not met as evidenced by:				
	records, the facility	ations, interviews and review of ty's governing body provided a direction over the facility, wing areas:				
	The finding includ	ies;	l 			
	_ =	ody failed to ensure the				
LABORATOR	RY DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X5) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 9D days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CM5-2567(02-99) Previous Versions Obsolete

Event ID: QKCR11

Facility ID: 09G174

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/29/2007 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(K3) DATE SURVEY COMPLETED	
		09G174	B. WING		06/26	3/2007
NAME OF P	rovider or supplier L		4	EET ADDRESS, CITY, STATE, ZIP CODE 422 20TH STREET, NE VASHINGTON, DC 20011		,
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFY(NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 104	Continued From pa maintenance of the evidenced by:	age 1 e facility's environment, as	W 104			
	frame; b. Pealing paint are	ound the exterior front window		Peeling paint around the exterior fro frames, panel next to the front door exterior front panels next to the gut front of the facility has been scraped	and ters on the	
, - -	c. Broken chair in	the backyard		repainted. The broken chair in the backyard habeen discarded.	is	
W 120	to the gutters on the Rust on fence p 483.410(d)(3) SER OUTSIDE SOURCE	ssure that outside services	W 120	See both A and B. The rusted areas on the backyard fe been removed and replaced with ne The house manager will complete a environmental check and forward a for repairs to maintenance.	w fencing. routine	7/31/07-O ngoing
	Surveyor: 19076 Based on observa record review, the monitor each clien the needs were monitor and the sample. (Client #1)			A current mealtime protocol has be forwarded to Client #1's day program QMRP met with day program staff the nutritional needs of Client #1. ensure that Client #1 is effectively in his day program by visiting routing providing ongoing training as neces regarding Client #1's support need.	am. The to discuss QMRP will monitored nely and sary	7/16/07 - Ongoing
	program on June : PM revealed that diet in a sectioned observation reveal	es: g the lunch mealtime at the day 25, 2007 at approximately 12:15 Client #1 was served a pureed paper plate. Further ed that Client #1 was eating at and was verbally prompted to				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED; 06/29/2007 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X2) DATE SURVEY COMPLETED	
	<u>. </u>	09G174 8. WING			06/26/2007		
!	NAME OF PROVIDER OR SUPPLIER SYMBRAL			STREET ADDRESS, CITY, S 4422 20TH STREET, NE WASHINGTON, DO	Ę		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	RTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECT CROSS-REFEREN	PLAN OF CORRECT CTIVE ACTION SHOU ICED TO THE APPRO IEFICIENCY)	JLP BE	(XE) COMPLETION DATE
W 122	and than suddenly plate while continuing staff physically/vertically/vertically and return to his meal. In an intestaff, on June 25, 2 PM, it was acknowled ground diet. Further #1 did have a current February 5, 2007 was on a ground diet. Assessment, dated 26, 2007 at approximated on the Decentry Client #1 was calone, low fat, low ground diet moister was no evidence Client as recommend program.	ng pace. The client complied got out of his chair holding his ing to consume the food. The bally had to stop the client from the table for the remainder of the table for the day interview revealed that Client interview revealed that Client indicated that the client et. Review of the Nutrition January 24, 2007, on June mately 2:30 PM revealed that ember 10, 2006, swallowing recommended an 1800 cholesterol, no added salt sed with gravy diet. There ient #1 was served a ground ed by the nutritionist in the day ROTECTIONS	W 1		to W120, W149 7263.	. W153,	
	Surveyor: 19076 Based on interview a failed to effectively a program to assure to met for Client #1[Re to ensure that system implemented to esta that ensure each clie	and record review, the facility monitor each client's day nat the dietary needs were fer to W120]; the facility failed ms had been developed and blish and implement policies ent's health and safety [Refernsure the immediate			·		

PRINTED: 06/29/2007 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO, 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09G174 06/26/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4422 20TH STREET, NE SYMBRAL, WASHINGTON, DC 20011 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LEC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) W 122 Continued From page 3 W 122 notification of the State officials of injuries of unknown origin and emergency medical services [Refer to W153]; and failed to thoroughly investigate injuries of unknown origin [Refer to W154]; failed to ensure effectively trained staff to implement emergency measures [Refer to W192]; failed to ensure that restrictive programs were used only with written consents IRefer to W2631. The effects of these systemic practices resulted in the failure of the facility to protect its clients from potential harm and to ensure their general safety and well being. W 124 483.420(a)(2) PROTECTION OF CLIENTS W 124 RIGHTS Assessment for legal guardianship will be completed 7/31/07-Ong for client #3 and pursuance for guardianship will oing occur based on the assessed needs of Clients #3. The facility must ensure the rights of all clients. Therefore the facility must inform each client. Additionally, QMRP will continue to ensure that parent (if the client is a minor), or legal guardian, family members are fully knowledgeable and of the client's medical condition, developmental understand the rights of the clients. OMRP will also and behavioral status, attendant risks of ensure documentation of information regarding all treatment, and of the right to refuse treatment. efforts to involve family members in the decision making process as well as ongoing measures (i.e., Human Rights Committee Reviews to discuss risk -vs- benefits) to ensure protection of their rights. This STANDARD is not met as evidenced by: QMRP will continue to pursue securing legal Surveyor: 19076 advocacy, as well as, guardianship resources through Based on observation, interview and record the quality trust, courts and other applicable verification, the facility falled to ensure the right of services, based on the individual needs for each each client or their legal guardian to be informed client. Documentation of these ongoing efforts will of the client's medical condition, developmental be maintained in the client records. and behavioral status, attendant risks of treatment, and the right to refuse treatment for Client #3's psychotropic medication regimen will one of two clients in the sample, (Client #3) continue to be evaluated monthly by the psychiatrist and psychiatric evaluations reviewed and updated per individual assessment and need The finding includes:

Observation of the evening medication

PRINTED: 06/29/2007

DEPART	MENT OF HEALTH	AND HUMAN SERVICES					06/29/2007
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES					APPROVED
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(XZ) M		TIPLE CONSTRUCTION NG	(X3) DATE SL COMPLE	0938-039 <u>1</u> JRVEY TED
		09G174	B. Wil	1G_		06/26/2007	
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		DIE-007
SYMBRA	ıl.		,	4	4422 20TH STREET, NE		
~ 1 m(710-	<u> </u>			ŀ	WASHINGTON, DC 20011		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	Ц.	PROVIDER'S PLAN OF CORRECT	ann -	
PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF		LEACH CORRECTIVE ACTION SHOP	II D AF	(X5) COMPLETION
.,,,		THE INCHASE OF SERVICES	TAG		CROSS-REFERENCED TO THE APPR DEFICIENCY)	OPRIATE	DATE
W 124	Continued From pa	ge 4	W	124			
		une 25, 2007 at approximately	•		[] .		
	5:55 PM, revealed	Client #3 received Risperdal			•		
į į	1.5 mg and Trazad	one 150 mg by mouth.			•		į
	Interview with the n	ursing staff on June 25, 2007					· :
	at approximately 6:	05 PM revealed that these					
i	Medications along t	with Haldel Deconpate 100 mg					
1	Management Don	was prescribed for bahavior					
	management. Review of the Client #3's physicians orders dated June 1, 2007 on June 26, 2007 at approximately 3;50 PM revealed that Risperdal 1.5 mg and Trazadone 150 mg by						ŀ
ł					•	.	
f	mouth twice a day :	and Haldel Decembate 100 mg					
	IM every two weeks	was incorporated in a				İ	
1	Behavior Support P	lan (BSP) dated February 21,					
	2007, to address be	ehaviors associated with					
	with the House Man	sical aggression. Interview			·		
	approximately 3-88	nager on June 26, 2007 at				i	
	not have a legal div	PM revealed that Client #3 did ardian or surrogate decision					
1	maker The review	of Client #3's Psychological					
	Assessment dated	February 4, 2007 on June 28,					
	2007 at approximat	ely 4:50 PM indicated that he					
	does not evidence t	the capacity to make					
	independent decision	ons on he behalf reparding his					
	habilitation planning), placement, treatment,					
	tinancial and medic	al matters and can not give					
	evidence that the f-	There was no documented acility informed Cliant #3 or a					
,	legally-authorized o	epresentative, as appropriate,					,
	of the health benefi	ts and risks of treatment]	
	associated with the	use of his psychotropic					
	medications and co	rresponding BSP.					
·	Additionally, the fac	ility failed to provide evidence					
	inat substituted con	sent had been obtained from					
W 149	a legally recognized	individual or entity.					
VV 143	CLIENTS	F TREATMENT OF	W:	149	3	•	
	The facility must de	velop and implement written				Ï	

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES			•	PRINTED): 05/29/2 007	
CENTE	RS FOR MEDICARE TOF DEFICIENCIES	& MEDICAID SERVICES	···		<u> </u>	FORM	APPROVED 0938-0391	
AND PLAN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDENSUPPLIENCLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
ļ. <u></u>		09G174	B. WIN	۷G _				
NAME OF	ROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·	 	ET		06/2	26/2007	
SYMBRA	L L				REET, ADDRESS, CITY, STATE, ZIP CODE 1422 20TH STREET, NE			
	····				VASHINGTON, DC 20011			
(X4) ID, PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEPICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOTH CROSS-REFERENCED TO THE APPR DEFICIENCY)	שם תונו	(XS) COMPLETION DATE	
W 149	Continued From pa	ge 5	W 1	1/10				
	policies and proced				,			
i i	This STANDARD is Surveyor: 19076	s-not met as evidenced by:						
	established policies	view and record review, the elop and implement its to ensure the health and sls clients in the sample. #5 and #6)						
	The finding includes	3 ;					}	
	develop a policy on a risk to client healti	153. The facility failed to reporting incidents that pose in or safety to governmental ed by DC regulation (22) Section 3519.10) as			The Program Director will revise and clar			
	Professional (QMRF approximately 4:15F did not report incides health or safety to the (DOH). Review of the Management Policy approximately 4:25F of abuse, neglect an reported no later that There was no docume facility reported incident health or safety.	"on June 25, 2007 at "on June 25, 2007 at "M revealed that allegations of mistreatment are to be in eight hours to the DOH, nented evidenced that the dente that posed a risk to by to the DOH.			agency's Policies and Procedures to furth identification, classification and handling incidents following regulatory guidelines, will be managed in accordance with DC r 22 DCMR Chapter 35 Section 3519.10. be re-trained on the incident reporting profile incident alleging abuse and neglect following the forwarded to DOH.	ner address of Incidents regulation Staff will ocedures	7/31/07	
	raboranti iucidente o	to implement their policy on f neglect to governmental d by DC regulation (22						

CENTE	IMENT OF HEALT! RS FOR MEDICARE	AND HUMAN SERVICES B MEDICALD SERVICES			· · · · · · · · · · · · · · · · · · ·	FORM): 06/29/2007 APPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION	CX3) DATE SURVEY COMPLETED	
		09G174	B. WING			,	
1	NAME OF PROVIDER OR SUPPLIER SYMBRAL			4	REET ADDRESS, CITY, STATE, ZIP CODE 422 20TH STREET, NE NASHINGTON, DC 20011	<u> 06/;</u>	26/2007
(X4) ID PREFIX TAG	1 (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECT IEACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRIES.	ים מונו	(X5) COMPLETION DATE
1	Interview with the I- 2007 at approximate facility did report all than eight hours to unusual incident regular evealed that Client staffing eloped from was no documente notified of the incidents agencies, as required agencies, as required by: Review of an unusual experimental agencies and unusual proving incidents agencies, as required by: Review of an unusual experimental agencies and revealed that Direct care staff. Interview prevealed that Direct immediately remove terminated her emplemental experimental experiment	douse Manager on June 25, tely 4:20 PM revealed that the legations of neglect no later the DOH. Review of an port dated May 25, 2007 on oppoximately 10:19AM it #3 who had one to one in the facility on that date. There is evidenced that the DOH was ent. to implement their policy on of abuse to governmental ed by DC regulation (22 Section 3519.10) as it incident report dated March (2007 at approximately 10:19 lient #3 was pushed by Direct the client spat on the direct with the House Manager on oppoximately 10:20 AM is Care Staff #1 was ed from duty and subsequently loyment from the facility. Incident Management 2007 at approximately 10:20 The dilegations of abuse, atment are to be reported no is to the DOH. There was no ge that this incident had been determined.	w 1	49	See page 6		
W 153	483.420(d)(2) STAF CLIENTS	nental agencies as required, FTREATMENT OF	W 1	53			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/29/2007 FORM APPROVED OMB NO. 0938-0391

STATEMEN	OF DEFICIENCIES	CAL SECUMENTURE PROPERTY.				OMB NO. 093B-0391	
AND PLAN C	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(XZ) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED 06/26/2007	
		09G174	B. Wil	B. WING			
SYMBRA	NAME OF PROVIDER OR SUPPLIER SYMBRAL			4	REET ADDRESS, CITY, STATE, ZIP CODE M22 20TH STREET, NE NASHINGTON, DC 20011	<u> </u>	
(X4) ID PREFIX TAG	I (EACH DEFICIENCY	TEMENT OF DEFICIENCIES I MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AFPR DEFICIENCY)	UID BE	(X5) COMPLETION DATE
. W 153	mistreatment, negle injuries of unknown immediately to the a	sure that all allegations of sect or abuse, as well as source, are reported administrator or to other nee with State law through	W	153			
	Surveyor. 19076 Based on interview Incidents that pose to governmental ag	s not met as evidenced by: and record review, report a risk to client health or safety encies, as required by DC IR Chapter 35 Section					
	1. Review of an unu June 20, 2007 on June 20, 2007 of the incident and incid	isual incident report dated une 25, 2007 at approximately that Client #2 was discovered his right arm. Interview with ron June 25, 2007 at 5 AM revealed she was aware that the facility's incident reded the incident to the incident to the incident had been that this incident had been nental agencies as required, usual incident report dated one 25, 2007 at approximately			Reference responses to W149 Additionally, QMRP will ensure that all reports are generated to all pertinent part investigated according to policy and produced to the produced response to the produ	ties and	7/31/07
	10:17AM revealed to one staffing eloped Interview with the M 2007 at approximate Direct Care Staff #2	ne 26, 2007 at approximately hat Client #3 who had one to from the facility on that date, ouse Manager on June 25, ely 4:20 PM revealed that was placed on administrative progress note dated May 25,					

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	05/29/2007 APPROVED
STATEMENT	MENT OF DÉFICIENCIES AN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA: IDENTIFICATION NUMBER:		(X2) MIL	JETIPLE CONSTRUCTION DING	(X3) DATE S	
		09G174	B' MIN	G	06/26/2007	
NAME OF PROVIDER OR SUPPLIER SYMBRAL				STREET ADDRESS, CITY, STATE, ZIP CODE 4422 20TH STREET, NE WASHINGTON, DC 20011		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI X (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	ADULD BE	COMPLETION DATE
W 153	2007 on June 26, 2 revealed that when facility on May 25, 2 was swollen. There that this incident ha governmental agent [Note: Review of a 2007 on June 26, 2 revealed that when facility on May 25, 2 Review of a radioto dated June 4, 2007 approximately revealed any fract 3. Review of an unit May 30, 2007 on June 30, 2007 on June 30, 2007 on June 30, 2007 on June 4, 2007 at approximately incident managemental evident and en approximately 10:11 of the incident and en approximately 10:11 of the en approximately	OUT at approximately 3:00PM Client #3 returned to the 2007, his left knee and ankle was no documented evidence d been reported to cles as required. progress note dated May 25, 007 at approximately 3:00PM Client #3 returned to the 2007, with a swollan left knee, gy report of the right/left knees on June 26, 2007 at aled that the Client #3 had not ures to the knees] usual incident report dated ane 25, 2007 at approximately hat while at the day program evered to have a "purple bruise of ring finger". Further review if was sent to the emerency and released with a finger the House Manager on June mately 5:23 PM revealed that en forwarded to the facility's ent coordinator. There was no ince that this incident had been mental agencies as required. Isual incident report dated the 25, 2007 at approximately that Client #6 sustained cuts as all incident report dated the 25, 2007 at approximately that Client #6 sustained cuts as all incident report dated the 25, 2007 at approximately that Client #6 sustained cuts as all incident report dated the 25, 2007 at approximately that Client #6 sustained cuts as all incident report dated the 25, 2007 at approximately that Client #6 sustained cuts as all incident report dated that Client #6 sustained cuts as all incident report dated that Client #6 sustained cuts as all incident report dated	W 1			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 06/29/2007 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING DINING R 096174 06/26/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4422 20TH STREET, NE SYMBRAL WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PREFIX PROVIDER'S PLAN OF CORRECTION PRÉFIX. (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETION COMPLETION EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC (DENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY W 153 Continued From page 9 W 153 documented evidence that this incident had been reported to governmental agencies as required. 5. Review of an unusual incident report dated April 24, 2007 on June 25, 2007 at approximately 10:19 AM revealed that Client #6 fell half-way down some staires and than hit his left hand on the doors plate glass which broke and he was sent to the emerency room. Further review revealed that the client was treated and released without sutures. Interview with the House See page 8 Manager on June 25, 2007 at approximately 10:20 AM revealed she was aware of the incident and that the facility's incident manager had forwarded the incident to the Department of Health (DOH). There was no documented evidence that this incident had been reported to governmental agencles as required. 6. Review of an unusual incident report dated March 2, 2007 on June 25, 2007 at approximately 10:22 AM revealed that Client #3 was pushed by Direct Care Staff #1 after the client spit on the direct care staff. Interview with the House Manager on June 25, 2007 at approximately 10:23 AM revealed that Direct Care Staff #1 was immediately removed from duty and subsequently terminated her employment from the facility. There was no documented evidence that this

agencies as required.

incident had been reported to governmental

7. Review of an unusual incident report dated June 29, 2006 on June 26, 2007 at approximately 10:24 AM revealed that Client #2 was discovered to have a bruise on his right arm. Interview with the House Manager on June 25, 2007 at approximately 10:25 AM revealed she was aware of the incident and that the facility's incident

_CENTE	MENT OF HEALTH RS FOR MEDICARI	HAND HUMAN SERVICES E & MEDICAID SERVICES			PRINTEI FOR!	D: 06/29/2007 MAPPROVED	
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(XZ) MUL A, BUILDI	TIPLE CONSYRUCTION ING	(X3) DATE COMPI) <u>. 0938-0391</u> SURVEY	
<u> </u>		D9G174	#. WING				
SYMBRA	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CO 4422:20TH STREET, NE WASHINGTON, DC 20011	DE 06/	26/2007	
(X4) ID PREFIX TAG	I CEACH DEFICIENCY	ATEMENT OF DEPICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		(X6) COMPLETION DATE	
W 153	documented evider	ige 10 Irded the incident to the Ith (DOH). There was no Irce that this incident had been Irental agencies as required.	W 153	1			
	approximately 10:20 fell and sustained a and was transported room and treated with the H 2007 at approximate was aware of the incident management incident to the D There was no document.	6 AM revealed that Client #2 I laceration on his forehead Id via 911 to the emerency Ith nine sutures and released. I louse Manager on June 25, ely 10:27 AM revealed she cident and that the facility's ent coordinator had forwarded Department of Health (DOH). Interest to provemental					
W 154	10:28AM revealed if the facility on that day the D.C. Matropo the House Manager approximately 10:30 aware of the incident managment the incident to the D.There was no document of the incident of the D.There was no document.	neual incident report dated ne 25, 2007 at approximately hat Client #4 had eloped from the at 2:00PM and was found elitan Police. Interview with on June 25, 2007 at 2 AM revealed that she was at and that the facility's to coordinator had forwarded epartment of Health (DOH), mented evidence that this eported to governmental at.	W 154				
	The facility must hav violations are thorou	re evidence that all alleged ghly investigated.					

PRINTED: 06/29/2007

DEPART	MENT OF HEALTH	AND HUMAN SERVICES				06/29/2007
		& MEDICAID SERVICES				APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(XC2) MULT	TIPLE CONSTRUCTION NG	(X3) DATE SU COMPLE	RVEY
		09G174	B. WING		06/26	S/2007
NAME OF P	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE	+ 	
SYMBRA	\L			4422 20TH STREET, NE WASHINGTON, DC 20011		
(X4) ID PREFIX TAG	(ÉACH DEFICIENC)	TEMENT OF DEFICIENCIES I MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REPERÊNCED TO THE APPR DEFICIENCY)	ULDBE	(XS) COMPLETION DATE
W 154	Continued From pa	ge 11	W 154	1		
	This STANDARD i Surveyor, 19076	s not met as evidenced by:			I	
	the facility falled to thorough investigat	and review of medical records document the provision of ions of injuries of unknown three clients in the sample, at #6)				
	The finding include	5 ,				
	June 20, 2007 on J 10:15 AM revealed to have a bruise on the House Manage approximately 10:1 that the incident ha	usual incident report dated fune 25, 2007 at approximately that Client #2 was discovered this right arm. Interview with ron June 25, 2007 at 6 AM revealed she was aware d not been investigated. There lat this incident of unknown ated.		Investigation of the incident involving C from the unusual incident report dated 6 be conducted.		
W 450	May 1, 2007 on Jun 10:17 AM revealed on the fingers of th House Manager on approximately 10:1 that the incident ha was no evidence the origin was investigated.	8 AM revealed she was aware d not been investigated. There lat this incident of unknown ated.		Investigation of the incident involving of from the unusual incident report dated of conducted. The investigation's and all supporting dowill be forwarded per policy and procedured.	5/1/07 will be	7/31/07
W 159	RETARDATION PI Each client's active integrated, coordin	FIED MENTAL ROFESSIONAL I treatment program must be ated and monitored by a lardation professional.	W 15!			·

DEPARTMENT OF HEALTH AND HUMAN SERVICES	
CENTERS FOR MEDICARE & MEDICAID SERVICES	

PRINTED: 08/29/2007 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. (IU)		LE CONSTRUCTION	(X3) DATE S COMPLE	
		09G174	B' MIV	IG	<u> </u>	06/2	6/2007
SYMBRA	ROVIDER OR SUPPLIER			44	EET ADORESS, CITY, STATE. ZIP CODE 22 20TH STREET, NE ASHINGTON, DC 20011		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
W 159	This STANDARD Surveyor: 19076 Based on interview Qualified Mental R. QUMRP) falled to e services for six of s #1,#2,#3,#4,#5 and The findings includ 1. The QMRP falle Client #1's day pro- served a ground di Observation during program on June 2 PM revealed that if diet in a sectioned observation reveal a very rapid pace a slow down his eath and than suddenly plate while continu- staff physically/ver eating and return this meal. In an inte staff on June 25, 2 it was acknowledge ground diet. Further #1 did have a curry was on a ground d Assessment dated 2007 at approxima "based on the Dec study Client #1 was calorie, low fat, low ground diet moiste	s not met as evidenced by: , and record review, the etardation Professional insure the coordination of six clients in the facility. (Client #6)			Cross reference response to W120.		7/31/07-Ongo ing

PRINTED: 06/29/2007 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (XZ) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING D9G174 06/25/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4422 20TH STREET, NE SYMBRAL WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PREFIX PROVIDER'S PLAN OF CORRECTION PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) W 159 Continued From page 13 W 159 diet as recommended by the nutritionist in the day program. 2. The QMRP falled to ensure that all staff had been effectively trained to implement emergency All staff lacking training in CPR will receive training. |7/31/07-Ong measures for six of six clients in the facility as evidenced by:

Interview with the House Manager on June 26. 2007 at approximately 4:58 PM revealed that all staff was not trained in CPR. Record review on June 26, 2007 at approximately 4:59 PM revealed that two out of eleven staff did not have current CPR certifications. There was no documented evidence that all direct care staff had CPR training and current CPR certifications.

3. The QMRP failed to ensure that all staff had been effectively trained to implement emergency measures for six of six clients in the facility as evidenced by:

in an interview with the House Manager on June Z6, 2007 at approximately 4:56 PM acknowledged that all staff was not trained in First Ald. Record review on June 25, 2007 at approximately 4:57 PM revealed that three out of eleven staff did not have current First Ald certifications. There was no documented evidence that all direct care staff had First Aid training and current First Aid certifications. 483.430(b)(5) PROFESSIONAL PROGRAM SERVICES

Professional program staff must be licensed. certified, or registered, as applicable, to provide professional services by the State in which he or she practices,

All staff lacking training in First Aid will receive training.

The QMRP and House Manager will review staff 7/31/07-Ong training needs on a monthly basis and register staff for training within 60-days of the expiration dates of current training. A schedule of upcoming training will continue to be posted in each facility,

oing

7/31/07-Ongo

ing

FORM CMS-2567(02-99) Provious Versions Obsoleta

W 170

Event ID: QKCR11

Facility ID; 09G174

W 170

If continuation sheet Page 14 of 24

DEPAR CENTE	TMENT OF HEALTH RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 06/29/2007 APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILL	LTIPLE CONSTRUCTION DING	(X3) DATE S	. 0938-0391 URVEY TED
·		D9G174	B. WING		ne/a	6/2007
SYMBRA	ROVIDER OR SUPPLIER		5	TREET ADDRESS, CITY, STATE, ZIP CODE 4422 20TH STREET, NE WASHINGTON, DC 20011	1 4012	012001
(X4) ID PREFIX TAG	I CEACH DEFICIENCY	Tement of deficiencies MUST be preceded by full SC identifying information)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE	DUID BE	(DUS) COMPLETION DATE
W 170	Continued From pa	ge 14	W 17	0		
	Surveyor, 19076 Based on staff inter facility failed to ensu	o not met as evidenced by: view and record review, the ure that all professionals are ified in accordance with the Laws.		The professional licenses for the Social Primary Care Physician have been obta Program Director will ensure that the p licenses of all consultants are in complimaintained on file in a conspicuous man HORA guidelines.	ined. The rofessional ance and	7/16/07
	The finding include:					
W 189	the professional lice Physician and Sociator review. There we Primary Care Physic currently licensed in 12, Section 3-1205. display the license of places of business of licensee.") 483,430(e)(1) STAF	innel records on June 26, tely 12:45PM indicated that conses for the Primary Care all Worker were not available as no evidence that the clan and Social Worker were accordance with the Health of Act (HORA), Title 3 Chapter 13 ("Each licensee shall conspicuously in any and all or employment of the FTRAINING PROGRAM invide each employee with a training that enables the or his or her duties effectively.	[∙] W 18	9		
	Surveyor: 19076 Based on observation review, the facility falenployee was provided in the control of the contro	not met as evidenced by: on, Interview and record iled to ensure that each ded with initial and continuing the employee to perform his	·			

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES			FORN	D: 06/29/2007 MAPPROVED
STATEMENT	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(PC2) MU A. BUIL	ALTIPLE CONSTRUCTION DING	(X3) PATE :	0, 0938-0391 SURVEY ETED
	<u>.</u>	09G174	B. WING	G	OG!	26/2007
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		20/2001
Symbra	\L		. }	4422 20TH STREET, NE WASHINGTON, DC 20011	ī	
(X4) ID PREFIX TAG	REGULATORY OR L	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR	HOLLDRE	(X5) COMPLETION DATE
W 189	Continued From pa competently.	ge 15	W 1	89		
	The findings include	a:				:
	ensure that staff ha	/153. The facility falled to directive training incidents to the Department		Reference response to W153. Cross W149.	reference	7/31/07-Ong oing
	2. Cross Refer to Wensure that staff has on investigating unu	/154. The facility falled to d received effective training usual incidents.		Reference response to W154.		
	3. Cross Refer to V ensure that staff ha implementing emen	V192. The facility staff falled to d received effective training in ency measures.		Reference response to W159 #2-3		
	ensure that staff had	440. The facility falled to d received effective training acuation drills quarterly on all		Reference response to W440.		
	ensure that staff had	V441. The facility failed to d received effective training acuation drills under varied		Reference response to W441.		
W 192		F TRAINING PROGRAM	W 19	92		1
	For employees who	work with clients, training				
	This STANDARD is Surveyor, 19076	not met as evidenced by:				
	review, the facility fa	on, staff interview and record iled to effectively train staff to by measures for six of six				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/29/2007 FORM APPROVED OMB NO. 0938-0391

STATEMENT	OF DEFICIENCIES	CV-1 BBG1 (BAC)	Τ			OWR NO	<u>. 0938-0391</u>
AND FLAN O	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A BUI		PLE CONSTRUCTION G	(X3) DATE S COMPLI	
		09G174	E, Wi	V G_		06/2	:6/2007
NAME OF P				4	REET ADDRESS, CITY, STATE, ZIP CODE 422 20TH STREET, NE VASHINGTON, DC 20011	1 0075	
(X4) ID PREFIX TAG	LEACH DEFICIENCY	TEMENT OF DEFICIENCIES. 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	III D RE	(X5) COMPLETION DATE
W 192	Continued From pa clients in the facility 5) The findings include	. (Clients #1, #2, #3, #4, 5 and	W	192	·		
	1. Interview with the 2007 at approximate staff was not trained June 26, 2007 at a revealed that two ocurrent CPR certific documented evider	e House Manager on June 26, rely 4:58 PM revealed that all ad in CPR. Record review on oproximately 4:59 PM ut of eleven staff did not have rations. There was no noe that all direct care staff had urrent CPR certifications.		;	Reference response to W159 #1.		
W 263	2007 at approximat that all steff was no review on June 25. PM revealed that the three current First And documented evihed First Ald training certifications.	e House Manager on June 25, sely 4:56 PM acknowledged trained in First Aid. Record 2007 at approximately 4:57 hree out of eleven staff did not ald certifications. There was dence that all direct care staff g and current First Aid OGRAM MONITORING &	w 2	263	Reference response to W159 #2.		
	are conducted only	uld insure that these programs with the written informed t, parents (If the client is a dian.					
	Surveyor: 19076 Based on observation review, the facility facilent's behavior into	on, staff interview and record alled to ensure that each ervention technique, including modification drugs was					

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM A	08/29/2007 \PPROVED 0938-0391
STATEMENT	of Deficiencies F Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(XZ) N A. BU		PLE CONSTRUCTION G	(X3) DATE SUI COMPLET	RVEY
		09G174	B. Wil	4G_		06/26	/2007
NAME OF P	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
SYMBRA	L				422 20TH STREET, NE VASHINGTON, DC 20011		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		Provider's Plan of Correct (Each Corrective action sho Cross-referenced to the appr Deficiency)	ULD BE	(75) Completion Date
W 263	the client, parents (guardian for one of (Client #3). The finding include Cross Refer to W1; informed consent parents as described to the administration on J 5:55 PM, revealed 1.5 mg and Trazad Interview with the rat approximately 6; medication was premanagement. Revenuel and the physicians orders of 2007 at approximately 1.5 mg amouth twice a day IM every two week Behavior Support 1 #3's Psychological 2007 on June 26, 2 indicated that he do to make independent regarding his habilities the fire the fi	written informed consent of If the client is a minor) or legal two clients in the sample set wo clients in the sample set. 24. The facility failed to obtain orior to the use of restrictive ribed in Client #3's Behavior) as evidenced by: evening medication lune 25, 2007 at approximately Client #3 received Risperdal ione 150 mg by mouth. The ascribed for behavior view of the Client #3's stated June 1, 2007 on June 26, tely 3:50 PM revealed that and Trazadone 150 mg by and Haldol Deconoate 100 mg so was incorporated in a Plan (BSP). Review of Client Assessment dated February 4, 2007 at approximately 4:50 PM coes not evidence the capacity and decisions on his behalf itation planning, placement, if and medical matters and can consent. Review of the BSP, 2007 on June 26, 2007 at that include elopement and on. Further review revealed a	W	263	Reference response to W124.		
	recommendation for	or a manuel restraint ned staff to control aggressive					

CENT	RS FOR MEDICARE	AND HUMAN SERVICES MEDICAID SERVICES			,	PRINTE: FOR:	D: 06/29/200 MAPPROVE	17 D
1 STATEME	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1			OMB NO	<u>0.0938-039</u>	1
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU		TIPLE CONSTRUCTION NG	(X3) DATE		
<u></u>		096174	B. Wi	NG.				
NAME OF	PROVIDER OR SUPPLIER	<u> </u>		τ_		06/	26/2007	
SYMB	تخا			١.	REET ADDRESS, CITY, STATE, ZIP CODE 4422 20TH STREET, NE		-	
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES			WASHINGTON, DC 20011			ı
PRÉFIX TAG	CEACH DEFICIENTS	/ MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	PREF		PROVIDER'S PLAN OF CORRECT (SACH CORRECTIVE ACTION SHOULD TO THE APPROVED TO T	W	COMPLETION DATE	7
W 263	Continued From pa	ge 18	157				 	4
· W 322	behavior, Interview record review on Ju 5:00 PM revealed to manuel restraint profession to one staffing Human Rights Comrequested, however facility falled to provinces. There was that the facility had consent for the use 483.450(a)(3) PHYS	with the House Manager and time 25, 2007 at approximately not staff has never used the occeedure on Client #3 also has support 24 hours a day. The imilities (HRC) minutes were at the time of the survey the ride evidence of the HRC in o documented evidence obtained written informed of Client #3's BSP.	w s					
	Based on observation review failed to provide for two of three #1 and Client #3) The findings include 1. The facility's medithat Client #1's psycimedical record as expending that the control of the exaministration on Jule:15 PM, revealed Comp and Depakote	ical services failed to ensure hotropic reviews were in the videnced by: vening medication ne 25, 2007 at approximately lient #1 received Loxapine 750 mg by mouth. Interview on June 25, 2007 at PM revealed that the			The Designated/Medication Nurse will ens Client #3 is encouraged, to participate in h medication administration to the extent of assessed capable,	is	7/16/07	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLA DESTRICTION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED (X4) ID PROVIDER OR SUPPLIER SYMBRAL (X4) ID PROVIDER OR SUPPLIER (X4) ID PROVIDER STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) W 322 Continued From page 19 management. Review of Client #1's Psychiatric Assessment dated August 30, 2004 on June 26, 2007 at approximately 1:10 PM revealed that Client #1 has an Axis I diagnosis of Autism. Review of Client #1's medical record on June 26, 2007 at approximately 1:15 PM revealed that there were no psychotropic reviews for April and	DEPART CENTER	RTMENT OF HEALTH	I AND HUMAN SERVICES & MEDICAID SERVICES				FORM	06/29/2007 APPROVED
NAME OF PROVIDER OR SUPPLIER SYMBRAL STREET ADDRESS, CITY, STATE, ZIP CODE 4422 20TH STREET, NE WASHINGTON, DC 20D11 (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) W 322 Continued From page 19 management. Review of Client #1's Psychiatric Assessment dated August 30, 2004 on June 26, 2007 at approximately 1:10 PM revealed that Client #1 has an Axis J diagnosis of Autism. Review of Client #1's Pm revealed that	STATEMENT AND PLAN C	NT OF DEFICIENCIES OF CORRECTION		- ((X3) DATE SI	URVEY
STREET ADDRESS, CITY, STATE, ZIP CODE 4422 20TH STREET, NE WASHINGTON, DC 20011 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) W 322 Continued From page 19 management. Review of Client #1's Psychiatric Assessment dated August 30, 2004 on June 26, 2007 at approximately 1:10 PM revealed that Client #1 has an Axis I diagnosis of Autism. Review of Client #1's medical record on June 26, 2007 at approximately 1:15 PM revealed that			D9G174	B. WIN	le _		O¢/a	C/OBOZ
SYMBRAL A422 20TH STREET, NE WASHINGTON, DC 20011 (X4) ID PREFIX TAG CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) W 322 Continued From page 19 management. Review of Client #1's Psychiatric Assessment dated August 30, 2004 on June 26, 2007 at approximately 1:10 PM revealed that Client #1 has an Axis J diagnosis of Autism. Review of Client #1's medical record on June 26, 2007 at approximately 1:15 PM revealed that	NAME OF P	PROVIDER OR SUPPLIER			57F	RET ADDRESS CITY STATE ZIR CODE	00/2	6/2007
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH CORRECTION ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) W 322 Continued From page 19 management. Review of Client #1's Psychiatric Assessment dated August 30, 2004 on June 26, 2007 at approximately 1:10 PM revealed that Client #1 has an Axis J diagnosis of Autism. Review of Client #1's medical record on June 26, 2007 at approximately 1:15 PM revealed that	SYMBRA	AL			4	422 20TH STREET, NE		
management. Review of Client #1's Psychiatric Assessment dated August 30, 2004 on June 26, 2007 at approximately 1:10 PM revealed that Client #1 has an Axis I diagnosis of Autism. Review of Client #1's medical record on June 26, 2007 at approximately 1:15 PM revealed that	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOL CROBS-REFERENCED TO THE APPRI	II D BE	(XS) COMPLETION DATE
May 2007. In an interview with the House Manager on June 26, 2007 at approximately 1:30 PM if was acknowledged that Client #1 did not have psychotropic reviews for April and May 2007 2. The facility's medical services failed to ensure that Client #3's psychotropic reviews were in the medical record as evidenced by: Observation of the evening medication administration on June 25, 2007 at approximately 5:55 PM, revealed Client #3 received Risperdal 1.5 mg and Trazadone 150 mg by mouth. Interview with the nursing staff on June 25, 2007 at approximately 5:05 PM revealed that the medication was prescribed for behavior management. Review of Client #3 Peychiatric Assessment dated February 8, 2007 on June 26, 2007 at approximately 3:30 PM revealed that Client #3 has an Axis I diagnosis of Chronic Undifferentiated Schizophrania. Review of Client #3 approximately 3:35 PM revealed that there were no psychotropic reviews for April and May 2007. In an interview with the House Manager on June 26, 2007 at approximately 4:40 PM it was acknowledged that Client #3 did not have psychotropic reviews for April and May 2007. 3. Cross refer to W331.1. The facility's nursing services failed to ensure that the results of Client #3. Medical staff in conjunction with QMRP and House Manager will ensure that the results of Elbotropic review forms are obtained and filed for Client #3. Medical staff in conjunction with QMRP and House Manager will ensure that the results of Elbotropic review forms are obtained and filed for Client #3. Medical staff in conjunction with QMRP and House Manager will ensure that the results of Elbotropic review forms are obtained and filed in the client #3. Medical staff in conjunction with QMRP and House Manager will ensure that the results of Elbotropic review forms are obtained and filed in the client #3. Medical staff in conjunction with QMRP and House Manager will ensure that the results of Elbotropic review forms are obtained and filed for Client #3. Medical staff in conjunction with QMRP and House Manage	W 322	management. Rev Assessment dated 2007 at approximat Client #1 has an Ax Review of Client #1 2007 at approximat there were no psych May 2007. In an int Manager on June 2 PM it was acknowle have psychotropic of 2. The facility's med that Client #3's psych medical record as a Observation of the administration on June 2 The facility's med that Client #3's psych medical record as a Interview with the n at approximately 6:1 medication was pre management. Rev Assessment dated 2007 at approximate Client #3 has an Ax Undifferentiated Sc #3's medical record approximately 3:35 no psychotropic rev In an interview with 26, 2007 at approximat psychotropic review 3. Cross refer to W: services failed to er	iew of Client #1's Psychiatric August 30, 2004 on June 26, tely 1:10 PM revealed that dis J diagnosis of Autism. 's medical record on June 26, tely 1:15 PM revealed that hotropic reviews for April and erview with the House 16, 2007 at approximately 1:30 adged that Client #1 did not reviews for April and May 2007 dical services failed to ensure chotropic reviews were in the evidenced by: evening medication une 25, 2007 at approximately Client #3 received Risperdal one 150 mg by mouth. ursing staff on June 25, 2007 05 PM revealed that the escribed for behavior lew of Client #3's Psychiatric February 8, 2007 on June 26, tely 3:30 PM revealed that that dis I diagnosis of Chronic hizophrenia. Review of Client I on June 26, 2007 at PM revealed that there were riews for April and May 2007. The House Manager on June mately 4:40 PM it was Client #3 did not have res for April and May 2007.	W 3		Nurse has followed up with the psychiatr the reviews from the psychotropic meetin April and May 2007. Nurse will ensure the clients records within 24 hours follow medication review. The EEG results have been obtained and Client #3. Medical staff in conjunction wand House Manager will ensure that the results have been that the results have been approximately and thouse Manager will ensure that the results have been obtained and client #3.	ngs held in hat the and filed in ing the filed for ith QMRP esults of	

CENTE!	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES [X1] PROVIDER/SUPPLIER/CLIA			FOR	D: 06/29/2007 M APPROVED D: 0938-0391
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILE	TIPLE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		09G174	E. WING		0.00	Opinon T
NAMEOFF	ROVIDER OR SUPPLIER	<u> </u>	.5	TREET ADDRESS, CITY, STATE, ZIP COD	. <u> </u>	26/2007
SYMBRA				4422 20TH STREET, NE WASHINGTON, DC 20D11	-	
(X4) ID PREFIX TAG	LEACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
W 322	Continued From pa	ge 20	W 32	2		<u> </u>
W 331	participated in a sel 483.460(c) NURSIN	f-medication program.	W 33	1		
	Based on staff inter facility failed to ensi	s not met as evidenced by: view and record review the ure nursing services in				
ļ	in the sample. (Clie	nt #3)		·		
	The findings include	ac				
	 The facility's nurs that the results of C obtained as evidence 	ing services failed to ensure lient #3's EEG studies were ed by:		Cross reference response to W322 #3		7/16/07
	zude on June 20, 20 revealed that Client that date and that the results, Interview will approximately 4:08 results were not obtained.	consult dated September 26, 2007 at approximately 4:05PM #3 had on EEG performed on the facility could call for the th LPN on June 26, 2007 at PM revealed Client #3's EEG aloned. There was no co that the results of the EEG and by the facility.				
	participated in a self	371.2. The facility's nursing sure that Client #3 -medication program. 3 ADMINISTRATION	W 37	Cross reference response to W322# J	l.	7/16/07

CENTE	KS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES			PRINTE FOR	D: 06/29/2007 MAPPROVED
I DIM LEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(XZ) MI A BUIL	JETIFLE CONSTRUCTION DING	(X3) DATE	<u>0. 0938-0391</u>
NAME OF 6	PROVIDER OR SUPPLIER	09G174	B. WIN	G	ne	16/500~
SYMBRA				STREET ADDRESS, CITY, STATE, ZIP CO 4422 20TH STREET, NE WASHINGTON, DC 20011	DDE	26/2007
(X4) ID PREKIX TAG	MOST DECILIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	I EU OLI II O AR	COMPLETION DATE
W 371	medications if the in determines that self	administration must assure ht to administer their own terdisciplinary team administration of medications	W 37	71 Cross reference response to W322	#1	
	Based on observation review of records, the an effective system participated in a self-for one of three client. The finding includes: The finding includes: During the observation pass, on June 25, 20, 20, 20, 20, 20, 20, 20, 20, 20, 20	on of the evening medication 107 at approximately 5:55 dministered Risperdal 1.5 mg mg by mouth by the LPN. Wed to bring a cup of water to me to receive his observation revealed that independently hold his up of water and consume t spillage. Client #3 was stolese 30 ml in a cup, mix stir the contents with a ning the medication. N on June 25, 2007 at was resemble that Client #3 had				

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES			PRINTE	D: 06/29/2007 MAPPROVED
1 O I A LEWIE V	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDENSUPPLIENCLIA IDENTIFICATION NUMBER;		LTIPLE CONSTRUCTION	(X3) DATE	<u>0.0938-0391</u> Survey
		·	A, BUILI B. WING		COMP	LETED
NAME OF	PROVIDER OR SUPPLIER	09G174	D. WING		ne.	<u>26/2007</u>
5YMBR			E	TREET ADDRESS, CITY, STATE, ZIP CODE 4422 ZOTH STREET, NE		EUI EUU I
				WASHINGTON, DC 20011		
(X4) ID PREFIX TAG	REGULATORY OR LE	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRE	M H I I NE	(XS) COMPLETION DATE
W 371	Continued From page	ge 22	14/ 27			<u> </u>
18/ 440	monitor level of par administration in the Individual Support F 2007 recommended self-medication". The client was given the self-medication pro-	ticipation medication next 90 days. Review of the lan (ISP) dated February 2, that Client #3 "leam ere was no evidence that the opportunity to participate in a	W 37			
W 440	()() <u>L</u> ()()	UATION DRILLS d evacuation drills at least	W 44	0		
	quarterly for each sh	lift of personnel.		The QMRP and House Manager will rev	iew the fire	
	outveyor 19076	not met as evidenced by:		drill records at least bi-weekly and moni implementation and documentation of fi ensure that fire drills are conducted on a basis for each shift under using different	tor the re drills to	7/16/07-Ong oing
	Based on record rev	lew, the facility falled to hold rterly on all shifts.		under varied conditions.		
	The finding includes:					1
,	てっ てんかん (おんを写)らり いい	use Manger on December at the staff schedules for the nd shifts are as follows:				
	Weekday Shifts are a	as follows:				1 1
	Day shift 9:00 AM [C Evening shift: 2:30 Pl Night shift: 11:00 PM	ilients go to day program] M to 11:00 PM I to 9:00 AM				
	Weekend Shifts are a	as follows:				
	Day shift: 9:00 AM to Overnight: 9:00 PM to	9:00 AM				
ĺ	11 PM ATCH 6, 2006, 1	le fire drill records dated to June 4, 2007 on June 25, y 9:45 AM revealed that fire				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/29/2007 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION	(X2) DATE SI	URVEY
					<u></u>		
		09G174	B. WIN	 		06/2	6/2007
SYMBRA	ROVIDER OR SUPPLIER			44	EET ADDRESS, CITY, STATE, ZIP CODE 122 20TH STREET, NE VASHINGTON, DC 20011		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Tement of deficiencies Must be preceded by full SC Identifying information)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEPICIENCY)	IOUI DIRE	(X5) COMPLETION DATE
W 440	Continued From pa	ge 23	W 4	40			<u>, </u>
W 441	drills were not cond shift during the second revealed that fire do night shift during the were not conducted fourth quarter. There	ucted on the day and night and quarter. Further review ills were not conducted on the lethird quarter and fire drills on the day shift during the was no evidence that every and ucted an evacuation drill at	V. 4				
	The facility must ho varied conditions.	ld evaculation drills under			Reference response to W440		
	Surveyor: 19076 Based on staff inter the facility failed to I varied conditions. The finding includes On June 25, 2007 a review of fire drill re House Manager rev year, staff had not p four egresess of the conducted via the fr	at approximately 9:45AM cords and interview with the realed that during the past practiced exiting through all a facility. Most fire drills were ont and side exits. There was accustion drills were being held			Additionally the QMRP/House Manage that staff receives in-service training of that will result in conducting drills at a conditions.	n fire drills	

Health Regulation Administration

STATEMEN AND PLAN (f of deficiencies Of Correction	(XI) PROVIDER/SUPPLIE IDENTIFICATION NUM	R/CLIA MBER;	A. BUILDIN		(X2) DATE SURVEY COMPLETED	
		09G174		B. WING_		06/2	6/2007
NAME OF P	ROVIDER OR SUPPLIER	. —			STATE, ZIP CODE		
SYMBRA	L		4422 20TH WASHING	istreet, Ton, DC 2	NE 80011	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	Ette i	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	CSHOULD BE	COMPLETE (XE)
R 000	INITIAL COMMENT	rs		R 000			
	Surveyor: 19076		1				-
	Based on interview failed to ensure that clearances on file.	and record review, t t all staff had police	he facility				
į	The finding include:	S .'					
,	2007 at approximat	personnel records on rely 4:40 PM revealed nce of a police cleara Staff (****) and *****	ino i	r	Police clearances have been obtain	ned for staff	7/12/07
	•	·					
			į				
isaith Regula	noitedainimbA nobe		<u></u> <u>-</u> <u>-</u> <u>-</u> <u>-</u> <u>-</u> <u>-</u> <u>-</u> <u>-</u>		TITLE		(XG) DATE

Health F	legulation Adm∫⊓istr	ation				FORM	APPROVED	
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM	R/CLIA MBER;	(XZ) MULT A. BUILDII B. WING		(X3) DATE SI COMPLE		
NAME OF F	ROVIDER OR SUPPLIER	09G174	PERCY AD	ADDRESS, CITY, STATE, ZIP CODE				
Symbra			4422 20TI	DRESS, CITY, H STREET, STON, DC (NE			
(X4) ID PREFIX TAG	LEACH DEFICIENC	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	EDITE:	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEPICIENCY)	JLD BE	(K5) COMPLETE DATE	
l 000	Surveyor, 19076 A licensure survey 2007 thru June 26, three residents was population of six m The survey findings In the group home interviews with resi program, nursing a Review of records, unusual incidents y	was conducted from 2007. A random sa selected from a resi ales with various disa were based on obseand three day progradents, residential, daind administrative staincluding investigations also conducted.	ample of ident abilities, ervations ms, y	1 001				
·	(GHMRP) shall con provisions stated in	or mentally retarded nply with the general chapters 13 through ict of Columbia Munic R).	17 of				•	
	Surveyor: 19076 Based on observati records, the facility general operating of except in the follow	•	eview of	•				
	maintenance of the evidenced by: a. Peeling paint aro frame;	s: / failed to ensure the facility's environmen und the exterior front und the exterior front	window		Peeling paint around the exterior front wi frames, panel next to the front door and exterior front panels next to the gutters of front of the facility has been scraped and repainted.	n the	7/16/07	
Galth Repub	ation Administration		hous)		<u></u>			
	and a section of an order				TITLE		KSI DATE	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

QKCR11

(XB) DATE

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		R/CLIA MBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED			
		09G174		B, WING			.	
NAME OF F	ROVIDER OR SUPPLIER		STREET ADD	DDRESS, CITY, STATE, ZIP CODE				
SYMBRA	AL		4422 20TH	TH STREET, NE GTON, DC 20011				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	E(II)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	linge	COMPLETE DATE	
1 001	Continued From pa	ge 1		1001			<u> </u>	
	next to the front door of the facility:							
	c. Broken chair in the backyard;				The broken chair in the backyard has bee discarded.	en	7/16/07	
	d. Peeling paint on the exterior front panels next to the gutters on the front of the facility; and				See page 1			
	e. Rust on fence po				The rusted areas on the backyard fence he removed and replaced with new fencing.	ias been	7/31/07-Ong oing	
l 041	3502.2(a) MEAL SERVICE / DINING AREAS			l 041	The house manager will complete a routi- environmental check and forward all req- repairs to maintenance.	ne uests for		
	Modified diets shall	be as follows:						
	(a) Prescribed in the resident 's Individual Habilitation Plan and the record of the prescription for the modified diet shall be kept in the resident 's record;							
	This Statute Is not a Surveyor: 19076	met as evidenced by	;					
	Based on observations, staff interview, and record review, the facility failed to effectively monitor each client's day program to assure that the needs were met for one of three residents in the sample. (Resident #1)		valy		A current mealtime protocol has been for Client # 1's day program. The QMRP me program staff to discuss the nutritional ne Client #1. QMRP will ensure that Client effectively monitored in his day program routinely and providing ongoing training a regarding Client #1's support needs.	et with day eds of # 1 is by visiting	7/16/07 - Ongoing	
	The finding includes	Ç				;		
	Observation during the lunch mealtime at the day program on June 25, 2007 at approximately 12:15 PM revealed that Resident #1 was served a pureed diet in a sectioned paper plate. Further observation revealed that Resident #1 was sating at a very rapid pace and was verbally prompted to slow down his eating pace. The client compied and than suddenly got out of his chair holding his plate while continuing to consume the food. The staff physically/verbally had to stop the client from eating and return to the table for the remainer of utation Administration				·			

<u>Health</u> F	legulation Administra	ation				FORM	APPROVED
STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM	R/CLIA MBER:	(X2) MÜLT A. BUILDIN B. WING	IPLE CONSTRUCTION	(X3) DATE S COMPLE	
NAME OF F		09G174				06/2	B/2007
NAMEOFF	ROVIDER OR BUPPLIER		ľ	· · · · · · · · · · · · · · · · · · ·	STATE, ZIP CODE		
5YMBRA	\L 		4422 20TI WASHING	H STREET. TON, DC 2	NE 6011		i
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SCIDENTIFYING INFORMA	FULL	ID PREFIX TAG			
1 041	his meal. In an interview with the day program staff on June 25, 2007 at approximately 12:25 PM It was acknowledged that Resident #1 was on a ground diet. Further interview revealed that Resident #1 did have a current mealtime protocol dated February 5, 2007 which indicated that the client was on a ground diet. Review of the Nutrition Assessment dated January 24, 2007 on June 26, 2007 at approximately 2:30 PM revealed that "based on the December 10, 2006, swallowing study Resident #1 was recommended an 1800 calorie, low fat, low cholesterol, no added salt ground diet moistened with gravy diet". There was no evidence Resident #1 was served a ground diet as recommended by the nutritionist in the day program.			I 041 .			
l 135	3505.5 FIRE SAFE Each GHMRP shall order to test the eff four (4) times a yea	I conduct simulated fi ectiveness of the plai	ire drilis in n at least	I 135			
	Surveyor: 19076 Based on record reversation drills que The finding includes Interview with the H 21, 2006 revealed t weekday and week Weekday Shifts are	s: louse Manger on Dec hat the staff schedule end shifts are as follo as follows: Clients go to day pro PM to 11:00 PM	d to hold cember as for the ows:		The QMRP and House Manager will revidual records at least bi-weekly and monit implementation and documentation of firensure that fire drills are conducted on a basis for each shift under using different under varied conditions.	or the e drills to quarterly	7/16/07-Ong oing

STATEMEN AND PLAN C	r of deficiencies Of Correction	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM	rvc <u>lia</u> MBER:	(XZ) MUL' A. BUILDI B. WING		(X3) DATE 8 COMPLI	URVEY ETED
NAME OF P	ROVIDER OR SUPPLIER	09G174	DYDEET ADE			06/2	6/2007
SYMBRA	•		4422 20TH WASHING	STREET	STATE, ZIP CODE NE 20011		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY I SC IDENTIFYING INFORMA	⊑ini †	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	4OUrnes.	(X5) GOMPLETE DATE
1 135	Continued From pa	ige 3		l 135		<u>.</u>	
:	Weekend Shifts and Day shift: 9:00 AM Overnight: 9:00 PM	ta 9:00 PM					
	from March 6, 2006 2007 at approximate drills were not conditionally shift during the secretealed that fire dringht shift during the were not conducted fourth quarter. There	able fire drill records on the June 4, 2007 on the June 4, 2007 on the June 2 and functed on the day and ond quarter. Further the third quarter and fird on the day shift during was no evidence the onducted an evacuation.	June 25, that fire night review ed on the e drills ng the	,			
l 161		AND PROCEDURES	į	I 181			
	The manual shall be body of the GHMR/ least annually.	e approved by the gov and shall be reviewe	verning ad at		The policy and procedure manual has and approved by the governing body. the review is on file in the policy and manual. The policies and procedures of the policies and procedure manual has and approved by the governing body.	Evidence of procedure	7/20/07
	Surveyor: 19076 Review of the policy June 25, 2007 at ap no evidence of an a governing body. In Mental Reatardation acknowledged that	met as evidenced by: / and procedure manu- peroximately 7:00 PM Innual review by the G an interview with the In Professional (QMRF) the annual review by the g body had not been c	Ial on revealed SHMRP's Qualified P) it was		reviewed by the governing body on ar	annual basis	,
		S AND PROCEDURE	1	J 163			
Į.	brocedutes tot at le	corporate policies and ast the following:	1				

Health F	legulation Administr	ati <u>on</u>				APPROVED
STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDENSUPPLIER/CLIA IDENTIFICATION NUMBER: 09G174	(X2) MUL A. BUILD B. WING		(X3) DATE S COMPL	
NAME OF P	ROVIDER OR SUPPLIER		1000000 alm		06/2	6/2007
				STATE. ZIP CODE	<u>-</u>	
SYMBRA	\L 	WASH	OTH STREET, INGTON, DC	, NE 20011		
(X4) ID PREFIX TAG	LEACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		
l 163	Continued From pa	ge 4	1 163			
	governing body, or, assessment of the management; This Statute is not Surveyor, 19076 Based on staff interfacility failed to device established policies	stration, which covers the panization charts, internal quality of care, and fiscal met as evidenced by: view and record review, the elop and implement its to ensure the health and six residents in the sample, #4,#5 and #6)				
	develop a policy on a risk to client healt	153. The facility falled to reporting incidents that pose h or safety to governmental ad by DC regulation (22				
	Professional (QMRI approximately 4:15F did not report incide health or safety to the (DOH). Review of the Management Policy approximately 4:25F of abuse, neglect an reported no later that There was no docur	ualified Mental Retardation a) on June 25, 2007 at M revealed that the faculity into that posed a risk to client is Department of Health the facility's "Incident " on June 25, 2007 at M revealed that allegations at mistreatment are to be an eight hours to the DOH, mented evidenced that the dents that posed a risk to y to the DOH.		The Program Director will revise a agency's Policies and Procedures to identification, classification and has following regulatory guidelines. In managed in accordance with DC reDCMR Chapter 35 Section 3519.1 re-trained on the incident reporting incident alleging abuse and neglect be forwarded to DOH.	to further address indling of incidents icidents will be egulation 22 0. Staff will be	7/31/07
_ [abounin iucidellæ 🗘	to implement their policy on f neglect to governmental d by DC regulation (22	,			

QKCR11

Health F	equiation Administra	ation	_			FORM	APPROVED
STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	R/CLIA MBER:	(X2) MUL A BUILDI B. WING		(X3) DATE S	
NAME OF F	ROVIDER OR SUPPLIER	090174	STOCET AD	00500 000		06/2	26/2007
SYMBRA			4422 20T	H STREET, STON, DC	STATE, ZIP CODE NE 20011		
(X4) ID PREFIX TAG	I (EACH DEFICIENC)	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	EI II I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	NO RE	(X5) COMPLETE DATE
l 163	evidenced by: Interview with the H 2007 at approximat facility did report all than eight hours to unusual incident rep June 25, 2007 at ap revealed that Client staffing eloped from was no documented notified of the incide	Section 3519.10) as fouse Manager on Julely 4:20 PM revealed egations of neglect nation of the DOH. Review of portoximately 10:19AN #3 who had one to contact the devidenced that the port.	I that the o later an 2007 on Mine ate. There	(163			
	reporting incidents of	to implement their pi of abuse to governme ed by DC regulation (Section 3519.10) as	ental I		See page 5		7/31/07
	A 2007 on June 25, AM revealed that Re Direct Care Staff #1 direct care staff. Int Manager on June 25, 10:20 AM revealed timmediately remove terminated her empi Review of the facility Policy" on June 25, 4:25 PM revealed the neglect and mistreat later than eight hour documented evidence reported to governmented to go	al incident report data, 2007 at approximate, 2007 at approximate after Resident #3 specified at a pproximate, 2007 at approximate, at allegations of abut the DOH. There to that this incident has a report at allegations of abut the DOH. There are that this incident hand agencies as report and agencies as report agencies agencies agencies as report agencies age	ed by ed by et on the etely #1 was sequently lity, nent ly tad no was no		Additionally, QMRP will ensure that all in reports are generated to all pertinent particity investigated according to policy and process.	es and	
- 1	3509.6 PERSONNE Each employee, prio	L POLICIES or to employment and		1 208	,		
ealth Regula	tion Administration						

Health R	equiation Administra	ation.				FURIN	APPROVED
STATEMEN AND PLAN	t of deficiencies of correction	(X1) PROVIDER/SUPPLIES IDENTIFICATION NUM	VCLIA IBER:	(X2) MULT A. BUILDIN B. WING		(X9) DATE SU COMPLE	
NAME OF B	ROVIDER OR SUPPLIER	030114	DTDEET AD	TOTOS OFT		06/26	5/200 7
SYMBRA			4422 20TI	H STREET, ITON, DC 2	STATE ZIP CODE NE 0011		
(X4) ID PREFIX TAG	(EACH.DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BIE PRECEDED BY I SC IDENTIFYING INFORMA	run l	ID PREFIX TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE		
1206	certification that a heriormed and that	age 6 shall provide a physinealth inventory has b the employee's hea her to perform the rec	een ith status	1 206			
	Surveyor: 19076 Based on interview	met as evidenced by: v and record review, to t all staff had current	he facility		The health certificates for all staff and or have been obtained. Program Director/H Resources will ensure that all health cert updated annually for each staff consultar maintained in the personnel records. Staff/consultants will be notified of the n submit a current health certificate within the current one's expiration.	iuman ifications are nt and seed to	7/20/07-ong oing
	at approximately 4: documented evider certificates for two LPN's, one RN, Pri Psychologist, Social Therapist consultar House Manager on approximately 5:10	nel records on June 26 59 PM revealed no nce of current health direct staff members, mary Care Physician, al Worker and Physica nts, in an interview wi	two ii in the ged that	·			
1 227	3510.5(d) STAFF T	RAINING		1 227			
Health Recul	(c) Infection control This Statute Is not Surveyor: 19078 Based on observati	am shall include, but ving: for staff and resident met as evidenced by: ion, staff interview and ailed to effectively trai	s; i record				

Health F	Regulation Administra	etion				FORM	APPROVED
STATEMEN AND PLAN	T OP DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM 09G174	R/CLIA MBER:	(X2) MULT A.BUILDII B. WING		(X3) DATE S COMPLI	URVEY
NAME DE P	ROVIDER OR SUPPLIER	U9G174	OTO C. T. NO.			06/2	6/2007
SYMBRA			4422 20T1	PRESS, CITY, H STREET, STON, DC 1	STATE, ZIP CODE NE 2001 1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	atement of Deficiencie Y must be preceded by SC identifying informa	FILL I	ID PREFIX TAG	REFIX (EACH CORRECTIVE ACTION SHOULD BE		
1227	residents in the fact 5 and 6 } The findings include 1. Interview with the 2007 at approximate staff was not trained June 26, 2007 at approximate two or current CPR certific documented evider	ncy measures for six ility. (Resident #1, #2	June 26, d that all wiew on not have	1227	All staff lacking training in CPR will rece training.	ive	7/31/07-Ongo ing
	2. Interview with the 2007 at approximat that all staff was no review on June 25, PM revealed that the have current First A no documented evice.	House Manager on tely 4:56 PM acknow of trained in First Aid. 2007 at approximate hree out of eleven static certifications. The dence that all direct on and current First A	June 25, ledgad Record ly 4:57 aff did not ere was		All staff lacking training in First Aid will training. The QMRP and House Manager will revitraining needs on a monthly basis and reg for training within 60-days of the expirate current training. A schedule of upcoming will continue to be posted in each facility	ew staff pister staff ion dates of a training	,
l 261	Each record shall be made available at a review by personne agencies.	EEPING: GENERAL e kept in a centralize times for inspection of authorized regula met as evidenced by	n end atory	l 261	The health certificates for all staff and co have been obtained. Program Director/If Resources will ensure that all health certiare updated annually for each staff consumantained in the personnel records. Staff/consultants will be notified of the nesubmit a current health certificate within the current one's expiration.	uman fications dtant and eed to	
1379	3519.10 EMERGEN	NCIES porting requirement i	n 3510 E	1379			
lealth Reput	ation Administration	t - · · · · · · · · · · · · · · · · · ·	11 90 13.5,				

Health Regulation Administration

STATEMEN AND PLAN	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION PROVIDER/QUPPLIER/CLIA IDENTIFICATION NUMBER:		R/CLIA MBER:	(X2).MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		D9G174		B. WING			
NAME OF F	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY	, STATE, ZIP CODE	D6/2	2 <u>6/2</u> 007
SYMBRA	ÁL		4422 20TH WASHING	STREET.	NF		
(X4) ID PREFIX TAG	I LEACH DEFICIENCY	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	C1111	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	i II D BE	(X5) COMPLETE: DATE
j	Health, Health Faci unusual incident or Interferes with a restarrangement, well to places the resident be made by telephotoliowed up by writto twenty-four (24) however to governmental agregulation (22 DCM 3519.10). The findings includes the followed of the telephotoliometry of the findings included the followed of the telephotoliometry of the findings included the findings included the findings of the telephotoliometry of the findings included the findings of the findings of the findings with the Health of the findings was aware of the incident manager has the finding of the finding	I notify the Departme lifties Division of any event which substants and the peing or in any other at risk. Such notification within an or the next work of the ast evidenced by and record review, in a risk to client health a rices, as required to R Chapter 35 Sections.	other Itally are, living way tion shall shall be day. aport or safety by DC charted oximately arm. ne 25, do she ident to	1379	The Program Director will revise and claragency's Policies and Procedures to furtification, classification and handling incidents following regulatory guidelines, will be managed in accordance with DC; 22 DCMR Chapter 35 Section 3519.10. be re-trained on the incident reporting profile incident alleging abuse and neglect for 3 will be forwarded to DOH.	nify the ner address of Incidents regulation Staff will	7/31/07
	reported to governme. 2. Review of an unumay 25, 2007 on July 10:17AM revealed to one staffing clope date. Interview with	ce that this incident hental agencies as reusual incident reportine 25, 2007 at appropart Resident #3 who defrom the facilty on the House Manager nately 4:20 PM reves	dated ximately had one				

ND PLAN	nt of deficiencies of correction	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM 09G174	R/CLIA MBER:	(X2) MULTI A. BUILDIN B. WING	IPLE CONSTRUCTION	(X3) DATE : COMPL	
AME OF I	PROVIDER OR SUPPLIER	03472	STOCKT AND	DEESE CHAY	STATE ZIP CODE	06/2	26/2007
SYMBR	NIHEAW			STREET, I	NE 0011		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	Etat 1	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
	leave. Review of a 2007 on June 26, 2 revealed that when facility on May 25, 2 was swollen. There evidence that this in governmental agen [Note: Review of a 2007 on June 26, 2 revealed that when facility on May 25, 2. Review of a radioliknees dated June 4 approximately revealed that when sustained any fracts. Review of an unumay 30, 2007 on June 22 PM revealed that the semerency room and with a finger splint. Manager on June 22 PM revealed that the forwarded to the fact coordinator. There that this incident had governmental agence 4. Review of an unumay 1, 2007 on June 10:17 AM revealed the cuts on the fingers of the House Manager approximately 10:18	2 was placed on administrated progress note dated (1007 at approximately Resident #3 returned 2007, his left knee and incident had been reported as a required. progress note dated for a proximately Resident #3 returned 2007, with a swollen on the region of the right (1, 2007 on June 26, 2007 at approximately and incident reported to have a "picky and ring finger". If a client #1 was sent to the was treated and relevant to the proximate incident management of the proported to have a "picky and ring finger". If a client #1 was sent to the proximate incident had been elimity's incident management of the proported to have a proximate incident management of the proported to have a reported to have a proximate of the proported to have a reported to have a proximate of the proported to have a reported to have a reported to have a proximate of the proximate of the proported to have a proximate provided the proported to have a proximate of the proximate provided the proported to have a proximate of the	May 25, 3:00PM I to the d ankie orted to Viay 25, 3:00PM I to the left knee First I had not lated eximately ogram urple Further orthe leased use tely 5:23 ement evidence atted mately elined view with	1379	DEFICIENCY) See page 9		

Health F	Regulation Administra	atlon			<u></u>	FORM	I APPROVED	
STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	R/CLIA MBER:	(X2) MULT A. BUILDIÉ B. WING		(X3) DATE : COMPL	ETED	
NAME OF P	ROVIDER OR SUPPLIER		STREET AD	ORESS CITY	STATE ZID CODE	06/2	26/2007	
Symbra			4422 20T	DORESS, CITY, STATE, ZIP CODE THISTREET, NE IGTON, DC 20011				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COI [EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SKOULD OF	(XS) COMPLETS DATE	
	Department of Heat documented evider reported to govern 5. Review of an unitary 10:19 AM revealed down some staires the doors plate glassent to the emerance revealed that the close of the emerance and that the facility forwarded the incid Health (DOH). There evidence that this in governmental agent 6. Review of an unutary 20:23 AM revealed by Direct Care Staff. In Manager on June 20:23 AM revealed immediately remove terminated her empthere was no documented the same of the company	arded the Incident to alth (DOH). There wa have that this incident mental agencies as nusual incident report that Resident #6 fell and than hit his left is which broke and the house with the House to the Department was treated and erview with the House 15, 2007 at approximate was no document is incident manager is and to the Department was no document incident had been republic as a required. Lisual incident report that Resident #3 was fift after the client specifies with the House 15, 2007 at approximate that Direct Care Stated from duty and substituted evidence the apported to doverning approximate evidence the apported to doverning a substituted the document from the face apported to doverning approximate apported to doverning a substitute that Direct Care Stated from duty and substituted evidence the apported to doverning approximate apported to doverning a substitute that Direct Care Stated from duty and substituted avidence the apported to doverning approximate approxima	s no had been equired. dated oximately half-way	1379	See page 9			
	2007 at approximate A	ouse Manager on Ju ely 10:25 AM reveale	ne 25, ed she					

Health F	Regulation Administr	ation				FORM	APPROVED
STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI 09G174	R/CLIA MBER:	(XZ) MULT A BUILDIN B. WING	IPLE CONSTRUCTION	(X3) DATE S COMPLE	ETED .
NAME OF F	ROVIDER OR SUPPLIER	000,14	STREET AN	DREES SITE	STATE, ZIP CODE	06/2	6/2007
SYMBRA			4422 20T	H STREET, STON, DC 2	NE		
(X4) ID PREFIX TAG	I (EACH DEFICIENC)	NTEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REPERENCED TO THE APPR DEFICIENCY)	HILDRE	(X5) COMPLETE DATE
1.37,9	Continued From pa	sge 11	<u></u>	1379			
	was aware of the in incident manager if the Department of documented evider reported to govern 8. Review of an unapproximately 10:2 #2 fell and sustaine and was transports room and treated with the incident management incident management incident to the incident was no document.	ncident and that the fa had forwarded the inc Health (DOH). There nce that this incident mental agencies as re usual incident report in June 25, 2007 at 5 AM revealed that R ad a laceration on his ed via 911 to the eme with nine sutures and touse Manager on Ju- tely 10:27 AM revealed toldent and that the fa ent coordinator had for Department of Health imented evidence the reported to governme	ident to was no had been equired. dated desident forehead rency released. Ine 25, ed she acility's Diwarded (DOH). If this		See page 9		
1 391	9. Review of an un May 13, 2006 on Ju 10:28AM revealed from the facility on the found by the D.C. Muth the House Man approximately 10:3 aware of the incident managment the incident to the Incident had been ragencies as require 3520.2(a) PROFES PROVISIONS	nusual incident reportune 25, 2007 at approtent that Resident #4 had hat date at 2:00PM a fetropolitan Police. It ager on June 25, 200 AM revealed that sint and that the facility at coordinator had for Department of Health mented evidence that eported to government.	eloped eloped nd was nterview 07 at ne was 's warded (DOH). t this ntal	l 39 1	Additionally, QMRP/Incident Managem Coordinator will ensure that all incidents are investigated as applicable and genera pertinent parties and investigated accord policy and procedure.	s reports ated to all	
	professional staff to	салу out and monito	or I	:			!
realth Reguli	noitatielnimbA neita				<u> </u>	;	1

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G174	(X2) MUL A. BÜİLDI B. WING	NG	(X3) DATE SURVEY COMPLETED	
NAME OF F	ROVIDER OR SUPPLIER		BOECE CITY	DTATE OF THE PARTY	06/26/2007	
SYMBRA	AL .	4422 20TI WASHING	H STREET, STON, DC	, STATE, ZIP CODE NE 20011		
(X4) ID PREFIX TAG	(EACH DEMCIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REPERENCED TO THE APPROVIDENCY) DEFICIENCY)	DRE COUNTY	
1 39 1	nacessary by the inforcessary by the inforcess	nal interventions, in goals and objectives of every policy and objectives of every policy pol	J 391			
	that Resident #1's pithe medical record a Observation of the e administration on Ju 8:15 PM; revealed R Loxapine 50mg and Interview with the nu at approximately 6:16 medication was pres management. Review Psychiatric Assessment on June 26, 2007 at revealed that Reside of Autism. Review o record on June 26, 2	cal services falled to ensure sychotropic reviews were in sevidenced by: vening medication ne 25, 2007 at approximately esident #1 received Depakote 750 mg by mouth raing staff on June 25, 2007 BPM revealed that the cribed for hehavior		The Designated Nurse has followed up with psychiatrist to obtain the reviews from the psychotropic meetings held in April and Ma for client's #1 and #3. Nurse will ensure th Psychotropic review forms are obtained and the client's records within 24 hours following medication review.	ay 2007 at the	

STATEMENT OF DEFICIENCIES AND FLAN OF CORRECTION (X1) PROVIDER/SUPPLIE IDENTIFICATION NU			(X2) MULTIPLE CONSTRUCTION A BUILDING B. WING		CA) DATE SURVEY COMPLETED - 06/26/2007		
			STREET ADD	RESS, CITY,	STATE: ZIP CODE		
4422.20TH			RESS, CAT, STATE, 217 GODE I STREET, NE ITON, DC 20011				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCILY Y MUST BE PRECEDED BY SC IDENTIFYING INFORM	(FULL)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	BHOULD BE	(X5) COMPLETE DATE
391	with the House Ma approximately 1:30 Resident #1 did no April and May 200. 2. The facility's me that Resident #3's the medical record Observation of the administration on 5:55 PM, revealed Riaperdal 1.5 mg amouth. Interview 25, 2007 at approxime medication was management. Resident # of Client	nd May 2007, In an in nager on June 26, 2 o PM it was acknowle thave psychotropic odical services failed paychotropic review.	oo7 at edged that reviews for to ensure s were in proximately ed mg by fon June vealed that eavior is 4, 2007 to I diagnosis enia. In April and use mately 4:40 to t#3 did not	; 391	See page 13		
1 35	PROVISIONS Each GHMRP sh professional staff nacessary profes	all have available quito carry out and mo	ialiffed nitor in	1 395			
1	individual habilita	the goals and object tion plan, as determi Interdisciplinary tear	ned to be				

Health F	<u>Regulation Administra</u>	ation				FORM	APPROVED	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G174		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED				
NAME OF P	ROVIDER OR SUPPLIER		STREET AD	DRESS CITY	STATE, ZIP CODE	06/2	<u>6/2007</u>	
SYMBDA1 4422 20TH			H STREET,	NE				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(XS) COMPLETS DATE		
1 395	Continued From pa	ge 14	-	1.395				
	professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services:		1.00	·	. :			
	(e) Nursing;							
	This Statute is not met as evidenced by: Surveyor: 19078 Based on staff Interview and record review the facility failed to ensure nursing services in accordance with the needs of one of three residents in the sample. (Resident# 3)				;	-		
	The findings include	a :						
	The facility's nursing services failed to ensure that the results of Resident #3's EEG studies were obtained as evidenced by:			The EEG results have been obtained and filed for Client #3. Medical staff in conjunction with QMF	vith OMRP	7/16/07		
	2006 on June 20, 2 revealed that Resid on that date and the results. Interview will approximately 4:08 EEG results were not documented eviden results were obtains		4:05PM performed If for the 2007 at ent #3's /as no the EEG		and House Manager will ensure that the relationship laboratory studies are obtained and filed client records.	results of in the		
	services falled to en	371.2. The facility's n sure that Resident# f-medication program	3		The Designated/Medication Nurse will en Client #3 is encouraged, to participate in I medication administration to the extent of assessed capable.	his	7/16/07	
1 436	3521.7(f) HABILITA	TION AND TRAININ	G	1 438				
lealth Regula	be limited to, the follation Administration	training of residents te, when appropriate, lowing areas:	by the but not					

Health F	Regulation Administr	atio <u>n</u>				FORM	APPROVED
STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(XI) PROVIDEN/SUPPLIER/C IDENTIFICATION NUMBER 09G174	CLIA ER:	(X2) MULT A. BUILDIN B. WING	IPLE CONSTRUCTION	(X3) DATE S	ETED
NAME OF F	ROVIDER OR SUPPLIER		THEET ADD	SECO FOR		06/2	6/2007
					STATE, ZIP CODE		
SYMBRA		V	VASHING	I STREET, TON, DC 2	NE 15011		
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATION	1L ON}	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOUI O SE	(X5) COMPLETE DATE
1436	Continued From pa	15 15		I 436		· <u>.</u>	<u> </u>
	use and self-admined, care and use of devices, preventive. This Statute is not Surveyor. 19076. Based on observative review of records, tan effective system participated in a se	uding skills related to nistration of medication, of prosthetic and orthotic health care, and safety met as evidenced by: ions, staff interview and he facility failed to Implet to ensure that each cliff-medication training pridents in the sample.	first ; ; ; ; ; the ement				
	pass, on June 25, 2 PM, Resident #3 was one of the table when had resident #3 was of the table when had resident #3 was at medication. Further Resident #3 was at medication cup and thre contents with cobserved to pour La	tion of the evening med 2007 at approximately 5 as administered Risperd 150 mg by mouth by the eserved to bring a cup of a came to receive his observation revealed to the to independently hole cup of water and consu- but spillage. Resident#3 actolose 30 ml in a cup, d stir the contents with a	:55 dal 1,5 e LPN. of water hat d his ume was		Cross reference response to L395-352).2 #2.	
	spoon before consultative with the Lapproximately 5:57 had a self-medication asself-medication asself-medication asself-medicated that Residemental to paradministration in the	iming the medication. PN on June 25, 2007 a PM revealed that Resident put did not assessment but did not assessment but did not assessment but did not program. Review o essment dated Februar 007 at approximately 4; lent # 3 was recommenticipation medication a next 90 days, Review Plan (ISP) dated Februar	at ant #3 not fithe y 2, 11PM ded "				

Health F	Regulation Administra	ation		•		APPROVED
STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI B. WING		(X3) DATE S COMPL	
NAME OF P	ROVIDER OR SUPPLIER		Difference of the		06/2	8/2007
				, STATE, ZIP CODE		
SYMBRA		WASHIN	TH STREET, GTON, DC	NE 20011		
(X4) ID PREFIX TAG	(BACH DEFICIENCY	TEMENT OF CEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOTH CROSS-REFERENCED TO THE APPRICENCY)	MARE	(X5) COMPLETE DATE
1436	Continued From pa	ge 16	1436			1
·	2007 recommende self-medication", Ti	d that Resident #3 "learn here was no evidence that the				
l 500	3523,1 RESIDENT	S RIGHTS	1 500			
	that the rights of re- protected in accord	tence director shall ensure sidents are observed and ance with D.C. Law 2-137, this applicable District and federal				
	Surveyor 19076	met as evidenced by:				
	verification, the faci each client or their I of the client's medic and behavioral state treatment, and the I	on, interview and record lity failed to ensure the right of egal guardian to be informed eal condition, developmental us, attendant risks of ight to refuse treatment for in the sample. (Resident #3		Assessment for legal guardianship will be for client #3 and pursuance for guardians occur based on the assessed needs of Client #3 and pursuance for guardians occur based on the assessed needs of Client #4 and pursuance for the formula fo	hip will ents #3.	7/31/07-Ong oing
	The finding includes			family members are fully knowledgeable understand the rights of the clients. OM!	e and IRP will also	
	Risperdal 1.5 mg ar mouth. Interview wit 25, 2007 at approxit	evening medication Ine 25, 2007 at approximately Resident #3 received Ind Trazadone 150 mg by In the nursing staff on June Mately 6:05 PM revealed that prescribed for behavior		ensure documentation of information reg efforts to involve family members in the making process as well as ongoing measu Human Rights Committee Reviews to dis —vs- benefits) to ensure protection of the	decision res (i.e., cuss risk	
	management, Reviphysicians orders da 26, 2007 at approxin Risperdal 1:5 mg ar mouth twice a day w	prescribed for panavior ew of the Resident #3's ated June 1, 2007 on June mately 3:50 PM revealed that ad Trazadone 150 mg by was incorporated in a Behavior dated February 21, 2007, to				

Health E	legulation Administra	<u>ation</u>				FORM	APPROVED
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBI	CLIA ER:	(X2) MULT A. BUILDIA B. WING	IPLE CONSTRUCTION	(X3) DATE 8 COMPLE	
NAME OF B	BOVIDES OF CHARLIES					05/2	6/200 7
140-MANE OL L				STATE, ZIP GODE			
SYMBRA	<u> </u>	\ v	M22 2DTI VASHING	H STREET, STON, DC 2	NE 10011		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATION	CN)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(XII) COMPLETE DATE
1 500	and physical aggre. House Manager on approximately 3:55 #3 did not have a ledecision maker. The Psychological Asse 2007 on June 26, 2 indicated that he do to make Independer regarding his habilitreatment, financial mot give informed or documented evider Resident #3 or a legenteresentative, as a benefits and risks of the use of his psychomesponding BSF failed to provide evisions approvide evision approvide evision approvide evision approvide evision approvide evision approvide evision approvide evision approvide evision approximately approvide evision approximately approvided evision approximately approvided evision approximately approxima	associated with elopemession. Interview with the June 26, 2007 at PM revealed that Resliegal guardian or surrogal guardian or Resident # 155 ment dated February 1007 at approximately 4 pes not evidence the behind the planning, placement decisions on he behind the planning, placement and medical matters a consent. There was no note that the facility informally-authorized appropriate, of the health of treatment associated hotropic medications are additionally, the facility idence that substituted optained from a legally	dent ate 3's 74, 55 PM pacity alf ent, nd can the	(500	QMRP will continue to pursue secundadvocacy, as well as, guardianship in the quality trust, courts and other asservices, based on the individual neclient. Documentation of these one is maintained in the client records. Client #3's psychotropic medication continue to be evaluated monthly band psychiatric evaluations reviewed per individual assessment and need	resources through pplicable eds for each coing efforts will a regimen will y the psychiatrist ed and updated	7/31/07-Ong oing
Health Regul	ation Administration	-			<u> </u>		